

# YWCA Youth Development Department

# TOP CAMPING TRIP



**Monday June 24th -  
Thursday June 27th**

**Drop-off:** Monday June 24th at YWCA 8:30AM

**Pick-Up:** Thursday June 27th at YWCA 2:00PM

**Camping at:**

Clay's Resort Jellystone Park  
12951 Patterson ST  
North Lawrence, OH 44666

About 45 minutes East of Cleveland, OH

## CAMPING SUMMARY

Students will be transported to and from camp and related activities in a charter/coach bus.

Once at Clay Resort, students will be staying in state park cabins with a TOP facilitator or chaperone and their same gender peers. During our trip, students will be enjoying swimming, group sports, campfire cooking, games, relaxing, movie night. There may be a movie option that is rated R. If you do not want your student viewing a R rated movie, please let their TOP facilitator know and they will be directed to a different movie option.

**In order for students to attend, please mail, or drop off at the YWCA,  
the completed camp forms by Wed. June 5th to:**

**YWCA of Northwest Ohio  
Attn: Tycie Alcorn  
1018 Jefferson Ave.  
Toledo, Ohio 43604**

**Facilitator Contact Info:**

**Director: Ms. Tycie Alcorn 419-241-3235**

**Ms. Quidrela 567-694-5502**

**Ms. Katie 419-318-7159**

**Jester 419-210-8764**

**Mrs. Gwenda 419-230-9212**

**Ms. Preshus 567-204-6599**



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Northwest Ohio



Teen Outreach Program  
YWCA of Northwest Ohio



Teen Outreach Program  
YWCA of Northwest Ohio

## TOP CAMPING TRIP Permission Slip

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STUDENT'S NAME

**This student [named above] has my permission to go on:**

**YWCA of NWO TOP Camping Trip celebration at Clay's Resort Jellystone Park  
with YWCA TOP staff person(s):** Tycie Alcorn, Quidrela Lewis, Katie Berger,  
Jester Zielinski, Gwenda Bevis, Preshus Lowe  
**Chaperones: TBD**

**When:** Monday June 24th - Thursday June 27th  
**Drop-off** (at YWCA Toledo) Monday June 24th at **8:30AM**  
**Pick-up** (at YWCA Toledo) Thursday June 27th at **2:00PM**

**You MUST have completed & turned in a health form packet  
& this signed permission slip to attend.**

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Parent/Guardian Signature

Date: \_\_\_\_\_

The above parent/guardian holds the YWCA of NWO faultless from any accident/injury resulting from participation with The Teen Outreach Program.

**If you have any questions, please contact us by phone at YWCA of Northwest Ohio  
Youth Development Department  
419.241.3235**



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**Personal History**

Student's Last Name (Printed)		Student's First Name (Printed)			M.I.
Street Address		Date of Birth ( Month, Day, Year)			Age
		School			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
City	State	Zip	Height	Weight	

**Emergency Contact Information**

Father/Guardian Name	Father/Guardian Home Phone	Father/Guardian Work Phone	Father/Guardian Cell
Mother/Guardian Name	Mother/Guardian Home Phone	Mother/Guardian Work Phone	Mother/Guardian Cell
Emergency Contact Name	Emergency Contact Phone	Relationship to Child	Emergency Contact Cell

**Medical Information**

*Please list any additional medications on a separate sheet and attach to your health form.*

“Medication” is any substance a person takes to maintain and/or improve his/her health & includes vitamins & homeopathic remedies.

- The student will not take any daily medications while attending **ywca** TOP Camp
- The student will take the following medication(s) while attending **ywca** TOP Camp. Bring enough of each medication to last their entire stay. All medications must arrive in appropriately labeled pharmacy containers.

NAME OF MEDICATION	REASON FOR TAKING IT	WHEN GIVEN & DOSAGE	DATE STARTED
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Dinner Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

The following medications will be available in our **ywca** First Aid Kits and are used to manage illness and injury as directed by our medical protocols. **Cross out those your student should NOT be given.**

- |                                |                                   |                                     |                     |
|--------------------------------|-----------------------------------|-------------------------------------|---------------------|
| Acetaminophen (Tylenol)        | Diphenhydramine (Benadryl)        | Docusate Sodium (Stool Softener)    | Tums                |
| Ibuprofen (Advil, Motrin)      | Technu Extreme (Poison Ivy)       | Loperamide HCL (Anti-Diarrhea)      | Cough Drops         |
| Pseudoephedrine (Sudafed)      | Silver Sulfadiazine ( Burn Cream) | Hydrocortisone Cream (Inflammation) | Calagel (Anti-itch) |
| Guafenesin DM (Cough Medicine) |                                   | Chloraseptic Spray (Sore Throat)    | Sunscreen           |

**Insurance Information**

*Please include a copy of your insurance card*

YWCA of Northwest Ohio Teen Outreach Program does NOT carry health/accident insurance for camping participants

Primary Policy Holder	Insurance company	Policy Number	Relationship to Child
Secondary Insurance Holder	Insurance Company	Policy Number	Relationship to Child
Physician's name	Physician's Phone Number	Date of Last visit	

**Health History**

**Allergies:** Check those that apply to your student.

- This student has no allergies.
- This student is allergic to this food(s). \_\_\_\_\_  
 Causes anaphylaxis?  Yes  No  
 Describe the reaction and how it is managed: \_\_\_\_\_
- This student is allergic to this medication: \_\_\_\_\_  
 Causes anaphylaxis?  Yes  No  
 Describe the reaction and how it is managed: \_\_\_\_\_
- This student is allergic to the following: \_\_\_\_\_  
 Causes anaphylaxis?  Yes  No  
 Describe the reaction and how it is managed: \_\_\_\_\_
- This student has been vaccinated for MMR ( this is usually administered before entering kindergarten)

**Nutrition:**

We prepare well-balanced meals. We can work with some medically prescribed diets but do not cater to individual food preferences.

- This students eats a regular diet.
- This student is the following type of vegetarian.
  - Semi-vegetarian (no pork or beef)
  - Pesco (no pork, beef, or chicken)
  - Lacto-ovo (no pork, beef, chicken, seafood or fish)
  - Vegan (no meats, seafood, eggs or dairy)
- This student does not eat pork because of faith reasons.
- This student is lactose-intolerant. Note: our expectation is that the student self manages using products such as Lactaid.

*Please call us if you have any questions pertaining to your students dietary needs .*

**Chronic Health Concerns:** Check those that pertain to your student and describe how it is handled at home.

- This student has no chronic health concerns and is capable of full participation in the **ywca** camp trip.
- This student has the following chronic health concern(s):
  - Asthma  Bedwetting  Seizure Disorder
  - Headaches  Menstrual Cramps  Frequent Colds
  - Sleepwalking  Frequent Ear Infections  Surgical History of Consequence
  - Diabetes  Fainting  Other

Information about items above (attach additional information if needed): \_\_\_\_\_

**Asthma or Anaphylaxis**  
 Please complete the additional "Request for information" forms attached.

**Mental, Emotional and Social Health**

Please check "Yes" or "No" for each statement

- 1. This student has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD.....  Yes  No
- 2. This student has a psychiatric diagnosis such as depression, OCD, panic /anxiety disorder.....  Yes  No
- 3. This student has an emotional health concern (specify).....  Yes  No
- 4. This student has seen or is currently seeing a professional to address mental/emotional concerns.....  Yes  No
- 5. This student has had a significant life event that continues to affect the student's life.....  Yes  No

If "Yes", please provide information about the event – death of a loved one, family change, adoption, new sibling, survived a disaster – its impact upon your student's life, and care tips for their time at camp.

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**When We Need To Talk With You:** We will certainly call in an emergency, but we'll also call if we have questions about your student's health. If we cannot reach you or your emergency contact at the numbers listed, please provide contact information for other people who know your student and with whom we can consult. We assume you have spoken to these alternative contacts and they are willing to assist should the need arise.

Alternate Contact \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Alternate Contact \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**What have We Forgotten to Ask?** Provide additional information about your child's health that may have been neglected on these forms. We are particularly interested in information that has an impact upon your child's ability to fully participate in our program.

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**ASTHMA MEDICATIONS**

Medications are supervised by the Director of Youth Development and locked in her cabin, with the exception of rescue inhalers that may be carried by the student. Medications are usually dispensed at mealtimes and before bedtime. While we'd like to use mealtime as much as possible to give routine medications, we can arrange a different time if needed (e.g. mid-morning, mid-afternoon).

**~My child does not have any form of asthma~**

**These Medications are Used Daily to Manage this Child's Asthma**

Name of Medication	Dose Given	When	Reason for Using this Med

**These Medications are Taken "As Needed" to Prevent an Asthma Flare**

Name of Medication	Dose Given	When	Reason for Using this Med

**These Medications are Used When this Child's Asthma Flares**

Name of Medication	Dose Given	At What Point Should this be Used?	What Effect Should be Expected & How Quickly?

**NEBULIZER TREATMENT & USE**

Will this child bring a nebulizer to the camp?.....  YES       NO

If YES..... We expect the child to know when s/he needs a nebulizer treatment and how to use the machine.

What medication is used via nebulizer? \_\_\_\_\_

Nebulizers will be kept in the Director of Youth Development's cabin and available when needed by the child.

**WHEN WE HAVE QUESTIONS, WHO SHOULD WE CONTACT?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**AT WHAT POINT SHOULD WE NOTIFY YOU (Parent/Guardian) ABOUT AN ASTHMA FLARE?**

**AT WHAT POINT SHOULD THIS CHILD BE TAKEN TO A PHYSICIAN OR HOSPITAL?**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Request For Additional Information About Your Child's Asthma**

We want your child to receive appropriate care and support for his/her asthma while attending our program. Please attach additional information as needed, including physician medication order or greater detail about your child's asthma history.

**About YWCA Camping Excursion....**

1. The program takes place in the outdoors. Your camper will be exposed to trees, grasses, dust , pollens, molds, insect bites and a host of other environmental factors.
2. We recommend that campers who use an "as needed" inhaler carry the inhaler with them (on their person). Please mark with the child's full name.
3. The closest hospital is UH Geauga Medical Center, approximately 4 miles away.
4. Staff is told that children with asthma are capable self-managers and that these campers know when to use their medication or amend activity to compliment their health status.

❖ **ABOUT TRIGGERS...**

What triggers your child's asthma?

- Exercise
- Fatigue
- Dehydration
- Stress
- Food Item
- Smoke
- Allergen\_\_\_\_\_
- Respiratory infections/common cold
- Other\_\_\_\_\_

Provide details about the trigger, including things which staff should be told..

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**PARENT/GUARDIAN AUTHORIZATION**

The information contained in this form is correct, as far as I know, and the child/student herein described has permission to engage in all camp activities except as noted. I understand that health/accident insurance coverage is the responsibility of the parent/guardian. I hereby give permission to **ywca** of Northwest Ohio to secure emergency medical, routine medical, surgical treatment, and non-surgical care for the child/student named on this form, while at camp. I absolve the **ywca** of Northwest Ohio and all of it's employees of any and all liability, financial and/or otherwise arising from administration of medication to my child under the terms of this release. **ywca** of Northwest Ohio is not responsible for payment of any medical expenses incurred during participation at camp.

In consideration for being allowed to participate in the **ywca's** programs, I agree to assume the risk of such activities and programs, and I further agree to hold harmless the **ywca** of Northwest Ohio, it's officers, employees and representatives from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accident or otherwise, during or arising in any way from the activities. I grant permission for my child to participate in all planned camp activities including our camp trips by van or bus, hiking or swimming. The **ywca** is not responsible for lost, stolen or damaged personal articles. I also authorize the **ywca** to have and use photographs and/or videos of my child, as may be needed for public relations. I acknowledge that this General Release of Liability and Authorization for Treatment of the **ywca** is binding on me personally and on my heirs, personal representatives, successors and assigns.

Limited Purpose Power of Attorney: Consent to Treatment of Minor (Must be signed by parent or legal guardian)

By signature below, the undersign appoints **ywca** facilitators, to act alone, or delegate to another person the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of

\_\_\_\_\_

(child's name)

determined to be necessary or desirable by our child's attending physician at the hospital.

This Power of Attorney shall continue through the participant's stay at camp, as well as transportation to and from camp and it's activities, or until revoked by the undersigned, whichever is earlier. Physicians or the hospital's medical staff may assume and rely on this authorization being current and in effect during such period unless notified otherwise.

The undersigned certify that they read this Power of Attorney (or had it read to them), that they understand this Power of Attorney, and sign it voluntarily.

Note: If this form is being signed for a child or minor participating at the camp, it must be signed by the parent or legal guardian. The signing parent should understand the indemnification clause above, defending **ywca** of Northwest Ohio against all claims by other parties on behalf of the child. This agreement will be enforced in accordance with the law of the State of Ohio.

Parent/Legal Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_